



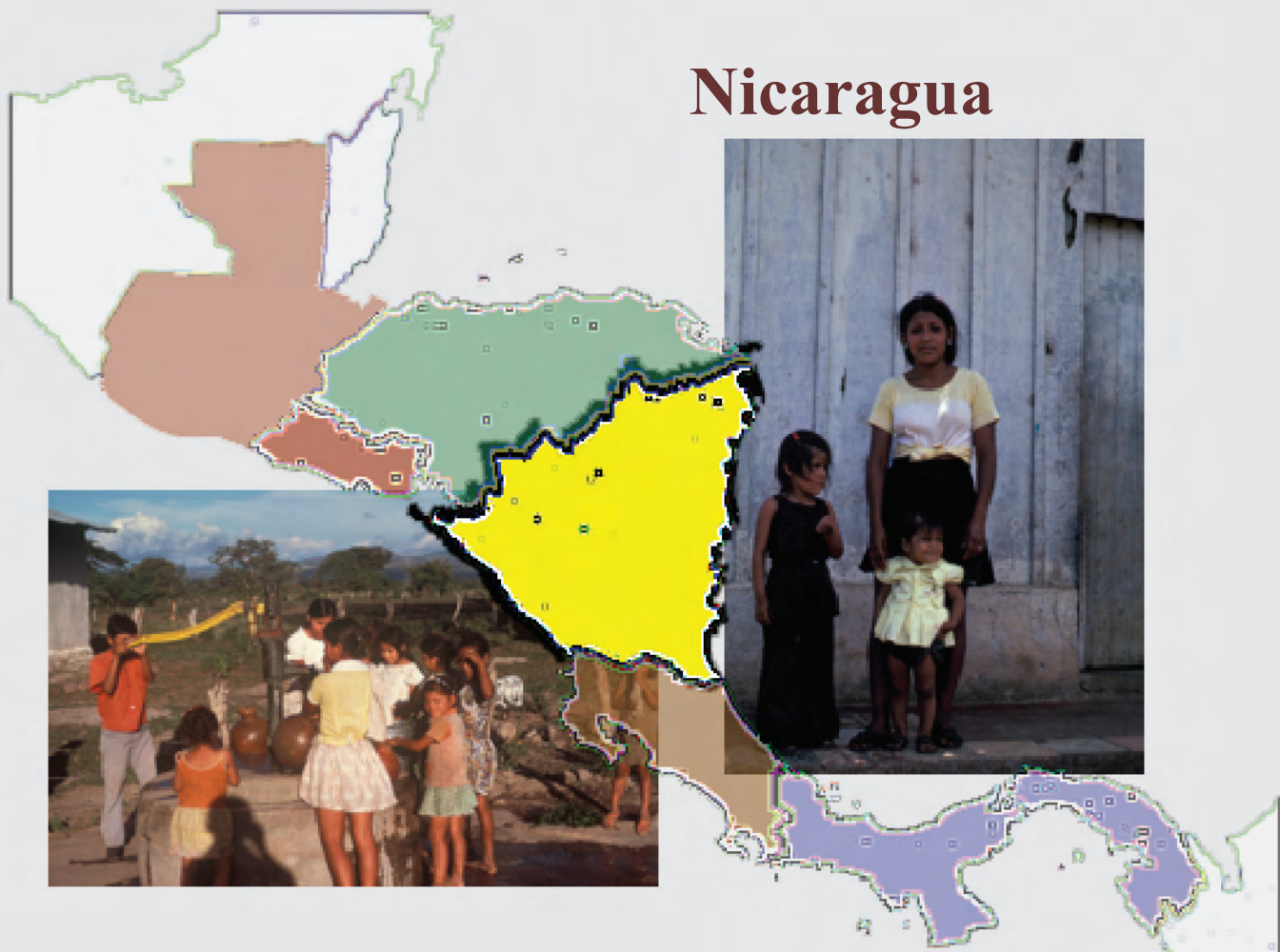
# Latin America and the Caribbean

and The Global HIV/AIDS Program

THE WORLD BANK

## Reducing HIV/AIDS Vulnerability in Central America:

*Nicaragua: HIV/AIDS Situation and Response to the Epidemic*



December 2006

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Central America**

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and Global HIV/AIDS Program

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December 2006

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## **Reducing HIV/AIDS Vulnerability in Central America** ***Nicaragua: HIV/AIDS Situation and Response to the Epidemic***

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This study was undertaken by the Human Development Department, Latin America and the Caribbean Regional Office (LCSHD) of the World Bank with financial support from the Bank-Netherlands Partnership Program (BNPP). The main objectives of the study were to establish a baseline for measuring progress and identifying new challenges for the Central America HIV/AIDS Regional Project, and to support policy dialogue regarding the political leadership and commitment to prepare a regional HIV action plan with common policies and coordinated strategies.

**Keywords:** HIV, AIDS, Central America, Nicaragua, World Bank

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## Acronyms and Abbreviations

<b>AED/F</b>	Academy for Educational Development and the Futures Group
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>ARV</b>	Antiretroviral Medicines
<b>ASONVIH</b>	Association of People Living with HIV and AIDS
<b>BNPP</b>	Bank-Netherlands Partnership Program
<b>CAFTA-DR</b>	Central American Free Trade Agreement – Dominican Republic
<b>CDC</b>	Centers for Disease Control
<b>CENIDH</b>	Nicaraguan Center for Human Rights
<b>CEPRESI</b>	Center for AIDS Education and Prevention
<b>CEPS</b>	Centro de Estudios y Promoción Social
<b>CONADEH</b>	National Human Rights Commission of Honduras
<b>CONISIDA</b>	Nicaraguan HIV/AIDS Commission
<b>CSW</b>	Commercial Sex Workers
<b>DNIM</b>	Office for Regulation of Medical Supplies
<b>DPAS</b>	Office of Care and Social Assistance, Nicaragua
<b>EU</b>	Education Unit
<b>GTZ</b>	German Agency for Technical Cooperation
<b>HCRH</b>	Carlos R. Huembes Hospital
<b>HIV</b>	Human Immunodeficiency Virus
<b>HIVOS</b>	Dutch Humanist Institute for Cooperation with Developing Countries
<b>ICAS</b>	Central American Institute for Social Action
<b>IDU</b>	Injecting Drug Users
<b>IEC</b>	Information, Education and Communication
<b>LCSHD</b>	LAC Human Development Department
<b>LCSHH</b>	Health Sector
<b>MINSA</b>	Ministry of Health
<b>MSM</b>	Men who have Sex with other Men
<b>NGO</b>	Non-Governmental Organization
<b>NORAD</b>	Norwegian Cooperation Agency
<b>PAHO</b>	Pan-American Health Organization
<b>PASCA</b>	Central American AIDS Action Project
<b>PASMO</b>	Pan-American Association for Social Marketing
<b>PEN</b>	Strategic National Plan
<b>PLWH</b>	People Living with HIV
<b>PLWHA</b>	People Living with HIV/AIDS
<b>SIDA</b>	Swedish International Development Cooperation Agency
<b>SIDALAC</b>	Latin American and Caribbean AIDS Initiative
<b>STD</b>	Sexually Transmitted Disease
<b>STI</b>	Sexually Transmitted Infections
<b>UNAIDS</b>	United Nations Fund Program for Prevention of HIV/AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children’s Fund

**USAID**  
**VIH**  
**WBIHD**

United States Agency for International Development  
Human Immunodeficiency Virus  
World Bank Institute Human Development Division

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## Executive Summary – Regional Overview<sup>8</sup>

In Latin America, Central America is the sub region most affected by the HIV epidemic after the Caribbean. Four of the six countries in Latin America with the highest HIV prevalence are in Central America, and two of them have prevalence rates above 1%. The epidemic threatens to run out of control unless prevention efforts among highly vulnerable groups, such as commercial sex workers, men who have sex with men and prisoners, are intensified.

Preventing new HIV infections, treating people with HIV/AIDS, and caring for those affected by the epidemic represents a great challenge for these six countries. The World Bank is currently supporting initiatives by Central American governments to reverse the HIV epidemic. In this context, this study was carried out with the following specific objectives:

- 1) Review the epidemiology of HIV and AIDS in Central America;
- 2) Assess National AIDS Programs, including surveillance systems, laboratory capacity, prevention, treatment and clinical care;
- 3) Assess the legal and regulatory framework, and discrimination against people with HIV and AIDS – particularly women – and its impact on treatment and prevention; and
- 4) Review successful interventions and good practices related to HIV in Central America, carried out by NGOs and public organizations, including to develop monitoring and evaluation systems.

This study was conducted to support the current policy dialogue on strengthening HIV/AIDS national responses, in particular to: (i) build political leadership and commitment to prepare a regional action plan with coordinated strategies and common policies, (ii) strengthen and harmonize the legal and institutional framework for addressing the HIV epidemic in the region, (iii) identify and disseminate “best practices” for prevention through integrated efforts by the health sector, other government agencies and civil society and promote monitoring and impact evaluations, and (iv) set out the rationale for establishing a regional procurement process for HIV-related pharmaceuticals and supplies.

Finally, this study established a baseline against which to measure progress and to identify new challenges for the World Bank-financed Regional HIV/AIDS Project to address. The development objective of the Regional Project is to provide knowledge and tools to decision makers in all countries in the region to manage and control HIV and opportunistic infections. Component 1, *Regional Laboratory*, supports the establishment of a regional laboratory to implement highly specialized functions, as a single regional institution. Component 2, *Epidemiological Surveillance*, supports the implementation of a regional second-generation epidemiological surveillance system, to enable improved

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<sup>8</sup> The study included Costa Rica, El Salvador, Guatemala, Honduras, Nicaragua, and Panama. Separate reports have been published on each country, and a regional overview, from which this summary is taken.

characterization of the HIV epidemic in Central America. Component 3, *Strengthening the Regional Response Capacity*, will increase the harmonization of legal and institutional frameworks needed to scale-up strategic interventions, in response to the HIV epidemic. It will also strengthen leadership and political commitment leading to a Regional Action Plan to address the epidemic in a coordinated way. Finally, component 4, *Prevention in Mobile Populations*, focuses on groups that are particularly vulnerable to HIV, i.e., mobile populations, considered to be a key factor in the spread of the epidemic. Prevention programs focusing on these populations are still few and small scale.

The information presented in this report was gathered in interviews with key stakeholders in Central America and from reviews of documents provided by national organizations, NGOs, and bilateral and international development organizations. In addition, seven workshops were held to present and discuss the information gathered by the study with the various stakeholders.

The study is published in a series of seven reports: one summarizes the HIV situation in Central America; the other six describe the situation in each Central American country. Information from different countries is not always comparable. This partly reflects differences in the organizational level of the different programs responding to the epidemic, as well as variations in the study's access to information held by different institutions and organizations.

### **Main Findings, Conclusions and Recommendations**

Honduras and Guatemala are two of the six countries with the highest HIV prevalence in Latin America. HIV prevalence among adults is already over 1% in Honduras (1.6%), and Guatemala (1%). Panama (0.9%), Costa Rica (0.6%), El Salvador (0.6%) and Nicaragua (0.2%) still have an HIV prevalence rate below 1%. By the year 2010, the epidemic may reach a 2% prevalence rate among the adult population in Central America, and in some cases it may surpass it.

It is estimated that over 200,000 people currently live with HIV in Central America.<sup>9</sup> HIV transmission in Central America is primarily associated with heterosexual sex, as in the Caribbean. The exception is Costa Rica, where men who have sex with men (MSM) account for a much higher share of infected people than in other countries in the region. Although there are more men than women with HIV in Central America, the gender gap is closing fast. The epidemic is still concentrated in high-risk groups such as commercial sex workers and their clients, men who have sex with men, prisoners, and the Garifuna (an Afro-Caribbean population group from the Atlantic Coast of Honduras). The increase in adult deaths from AIDS has led to a rising number of orphans and vulnerable youth being left without homes, food, health care and education. The epidemic has economic repercussions both for households and country health systems, as well as for the economy.

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<sup>9</sup> CDC. Global AIDS Program for Central America. Program Profile, 2004.

In addition to the variations in prevalence and groups affected across the six countries, there are also important variations within each country. The epidemic is concentrated in certain geographic areas – particularly urban areas, internal commercial routes and ports. Groups associated with mobile populations, commercial sex workers and men who have sex with men have the highest prevalence of HIV, and are bridge populations for transmitting the epidemic to the general population, mainly due to them engaging in risky behaviors and the high level of interactions between these groups and the general population. However, the mechanisms of HIV transmission need to be better known so that effective public health interventions can be designed and implemented. Identifying the nature and extent of the problem in certain groups – such as people with disabilities, children at risk of sexual abuse, prison inmates, ethnic minorities, businessmen and the military/police – remains a challenge.

There are important differences in social and economic conditions among the Central American countries which may partly explain the differences in HIV prevalence rates. Other factors contribute to the epidemic, such as migration, tourism and proximity to the Caribbean. Migration has two components: 1) temporary workers moving within countries in this sub region; and 2) migrants attempting to move permanently to the United States, of whom only about 10% succeed, while 90% return to their countries. While in transit, migrants may be exposed to high risk sexual behavior, increasing their risk of becoming infected with HIV and other sexually transmitted infections. Higher HIV prevalence rates in Honduras, San Pedro Sula (a Caribbean port) and among the Garifuna population (indigenous people with roots in the Caribbean) suggest that transit between Central America and the Caribbean has had an impact on the Central American epidemic.

Some of the differences in HIV prevalence among these countries may be explained by poor surveillance systems and under-reporting. For example, although the role of injecting drug users (IDUs) does not seem to be an important factor in the epidemic in Central America, this may be the result of under-reporting. The higher HIV prevalence reported among MSM in Costa Rica may reflect more liberal cultural norms and less discrimination in this country, rather than real differences between Central American countries.

Once an HIV epidemic becomes generalized, the most affected groups are people in the prime working years of life. This has negative consequences for labor force size and productivity, with long-term repercussions for both the economy and health system, as has been witnessed in Africa. Countries such as Brazil, Thailand and Uganda have shown, however, that it is possible to keep the epidemic in check if there is strong country leadership, and evidence-based, cost-effective interventions that achieve high coverage of highly vulnerable groups such as commercial sex workers and men who have sex with men, are implemented.

### **National Responses**

All Central American countries have established coordinated national responses to address the HIV epidemic. Nonetheless, important challenges remain to make these

systems effective. With respect to prevention, the main challenge continues to be to effectively reach the most vulnerable groups with evidence-based and cost-effective interventions, including appropriate prevention strategies to promote healthier and safer sexual and reproductive practices. On the treatment side, responses need to provide not only anti-retroviral drugs but also all the necessary clinical support and follow-up. At the regional level, efforts supported by the World Bank-financed project and other organizations will continue to focus on inter-country “transmission corridors” and border areas.

It is essential that each country defines national strategic priorities and allocates resources that reflect the realities of its own epidemic. Surveillance systems are still very weak, and most focus on notification of AIDS cases only. However, some of the necessary information about the epidemic is available and is included in this study. The Central American countries need to improve the analysis of available data to allow for appropriate planning and execution of national HIV/AIDS policies and programs.

Vulnerable groups and the general population still have a very limited understanding of HIV and AIDS. Swift action is required to discourage risky sexual practices, especially among highly vulnerable groups, and to better identify HIV cases and provide ARV treatment. A specific challenge is coordinating the actions of NGOs and the public health services, especially to provide effective responses at the three levels of care.

The country workshops that discussed the study findings and analyzed cost-effective intervention strategies concluded that at current resource levels, only 25% of infections could be prevented. This reflects the difficulty of reaching groups at greater risk. Cost-effective strategies identified by workshop participants include: i) free distribution of condoms among highly vulnerable and vulnerable groups, ii) social marketing of condoms, iii) targeting information, education and communication at highly vulnerable and vulnerable groups; and iv) providing counseling and access to rapid diagnostic tests.

Current funding to prevent and control the epidemic is far from adequate, and needs to be allocated to prevention among high risk and highly vulnerable groups. The World Bank developed a cost-effectiveness model to help governments determine the allocation of resources that would prevent the maximum number of new infections. According to this model, a well designed national program can have a substantial impact on the epidemic even with limited resources, provided these are channeled to the most cost-effective interventions. An analysis in Guatemala, Honduras and Panama suggests that health spending would have to increase by \$1 million per year to prevent the number of patients from growing 10-20%. In 2000, the three countries spent approximately \$9.6 million on HIV/AIDS programs.<sup>10</sup>

***Surveillance Systems.*** Surveillance of HIV and AIDS in Central America is based on mandatory notification of cases, and some prevalence studies. At the country level, by merely identifying and following up on HIV and AIDS cases, surveillance systems do not

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<sup>10</sup> The World Bank. HIV/AIDS in Central America: The Epidemic and Priorities for its Prevention. LAC Region: Washington DC: 2003

fully respond to information needs posed by the dynamic of the epidemic. These systems need to increase their capacity to gather and analyze data related to risk factors and behaviors, known as second-generation surveillance. Upgrading the system to second-generation requires new strategies (sentinel units and sites). At the regional level, it is necessary to agree on common standards that will allow the exchange of information among countries, as well as on case definitions, implementation of sentinel units and sites, case reports, and indicators. To achieve this goal, it is important to consider the development of a regional integrated electronic information platform.

***Legal and Regulatory Framework.*** Although all countries have developed a legal framework for health care provision for people living with HIV and AIDS (PLWHA), many cases of discrimination have been reported, and PLWHA have had to file law suits to defend their rights. In some countries, contradictions among the laws need to be resolved. In addition, improving knowledge about people's rights under the law remains a challenge, as does defining and implementing sanctions for discrimination. Successful interventions in the field of human rights, particularly in Guatemala and Panama, have seen a number of cases resolved in favor of patients who filed complaints. The study was able to identify areas where changes in general legislation or HIV/AIDS laws are necessary. Issues of reciprocity in treatment and care need to be resolved. Regional organs such as the Central American Integration System (SICA) can provide the necessary umbrella to integrate legal frameworks at the regional level.

***Prevention.*** All countries have taken a broad approach to the prevention and control of the HIV epidemic. The list of potential target groups has increased to include the whole population. This strategy should be reviewed to ensure that the limited resources available are allocated to groups that are critical for preventing transmission of the virus – commercial sex workers, men who have sex with men, prisoners, and mobile populations.

In Central America, in addition to public services, there are many NGOs supporting the national responses against HIV and AIDS. These NGOs cover a wide range of interventions, offering protection of human rights, and prevention, treatment and care services. Judging from coverage indicators, many of these projects have been successful in achieving their goals. However, many interventions only track process indicators, and their outcomes are unknown.

Some projects are able to report on results: for example, an increase in the use of condoms by the target population was observed in Guatemala following a social marketing effort by PASMO. Similarly, the Basic Food Basket project of the Ministry of Health in El Salvador has shown a reduction in mother-to-child transmission of HIV. Projects aimed at the Garífuna population in Honduras have great potential. The same can be said of programs targeting the Xochiquetzal population in Nicaragua and of an effort by the United Nations Population Fund (UNFPA) and the Youth Ministry to draw attention to the epidemic in Costa Rica. Two successful interventions involve translating prevention messages for the Honduran Garífuna into the indigenous language. However, issues involving indigenous and afro-descendant groups in the region are very complex and require more attention. Some projects were successful in transferring knowledge to

vulnerable groups. However, most interventions have not selected indicators to measure impact on outcomes, such as HIV prevalence in vulnerable populations. The lack of appropriate measurement mechanisms does not mean that these interventions have not had an impact, or will not have one in the future. Rather, it points to the need for better monitoring and evaluation systems, including better indicators.

***Treatment and Care.*** All Central American countries are providing treatment and care to people living with HIV and AIDS (PLWHA), including access to ARTs. Treatment is delivered through a mix of public and private care. The coordination of follow-up activities by health services and NGOs that provide ART is a serious challenge for country programs. In fact, there are significant challenges regarding the management of adverse effects of treatment, follow up with laboratory tests, and ensuring adherence to treatment. Dealing with illiterate patients or ethnic groups, many of whom are not covered by healthcare, adds to the challenge.

All countries also face challenges regarding the availability of ARVs. Agreements have been reached to attain preferential prices for brand-name drugs. In addition, generic medicines are available through institutional bidding processes or through procurement agencies and international foundations. Specific challenges remain in planning joint purchases by Ministries of Health and Social Security institutions, having uniform treatment protocols, establishing an infrastructure for patient follow-up, and monitoring resistance to medicines.

At the national level, countries need to establish mechanisms to facilitate the purchase of high quality generic drugs, using mechanisms such as the PAHO Revolving Fund or bilateral agreements. At the regional level, the possibility of establishing an alliance of Central American countries for the bulk purchase of drugs, aiming at reducing costs, should be considered. This alliance would improve these countries' bargaining power, ensuring access to drugs and related supplies at lower prices.

***Laboratory Capacity.*** At the national level, laboratory capacity needs to increase not only to provide diagnostic services, but also to be able to follow up on people receiving ART. This will require investment in equipment and skilled workers; and improvements in health services referral processes. At the regional level, the World Bank is supporting the establishment and implementation of a regional laboratory in Panama City. This facility will have the following functions to support national laboratories: (i) diagnostic and follow up testing for complex cases, (ii) access to, and transfer of new laboratory technologies, (iii) quality control, (iv) training in new techniques, (v) research, and (vi) development of an integrated information system with country laboratories.

## Nicaragua: HIV/AIDS Situation and Response to the Epidemic

This section presents information on the status of HIV and AIDS in Nicaragua. It begins by examining HIV and AIDS epidemiology in the country, and continues with a presentation on how the general population perceives the epidemic. The final section includes information on the national response to HIV and AIDS.

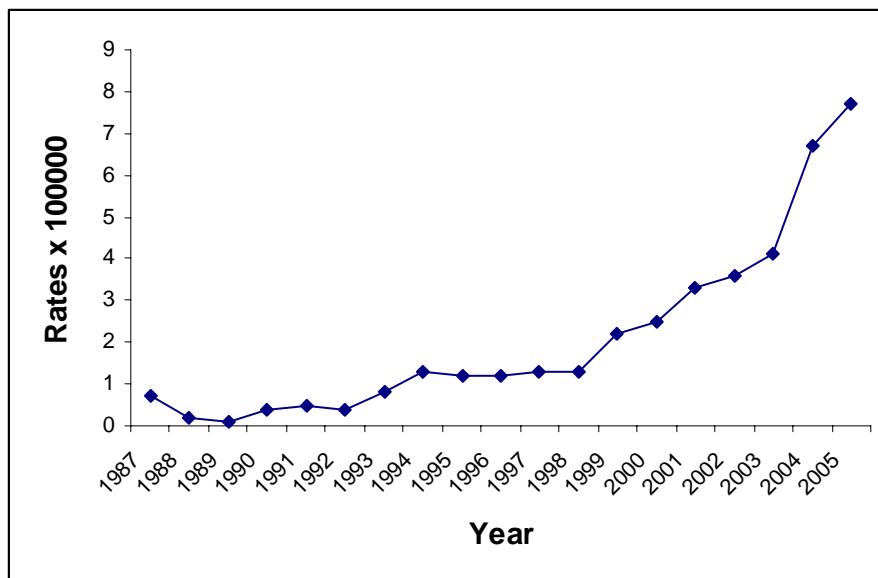
### HIV and AIDS Situation

HIV was not detected in Nicaragua until 1987, after the epidemic was quite widespread in other Central American nations. Various factors may have contributed to the delayed start of the epidemic in this country. Nicaragua's 10 years of civil war and the economic blockade led by the United States left the country isolated for a number of years. In addition, relative control over commercial sex work, low infection rates among intravenous drug users, and a ban on the commercial sale of blood, slowed HIV transmission.

HIV has not been a priority or a national concern in Nicaragua. This impairs many aspects of the national response to the epidemic. For example, there is a need to improve voluntary testing and counseling services, and to reform the laws protecting the rights of people with HIV. Epidemiological surveillance in Nicaragua has also evolved slowly.

Graphs 1 and 2 present data on reported HIV cases.

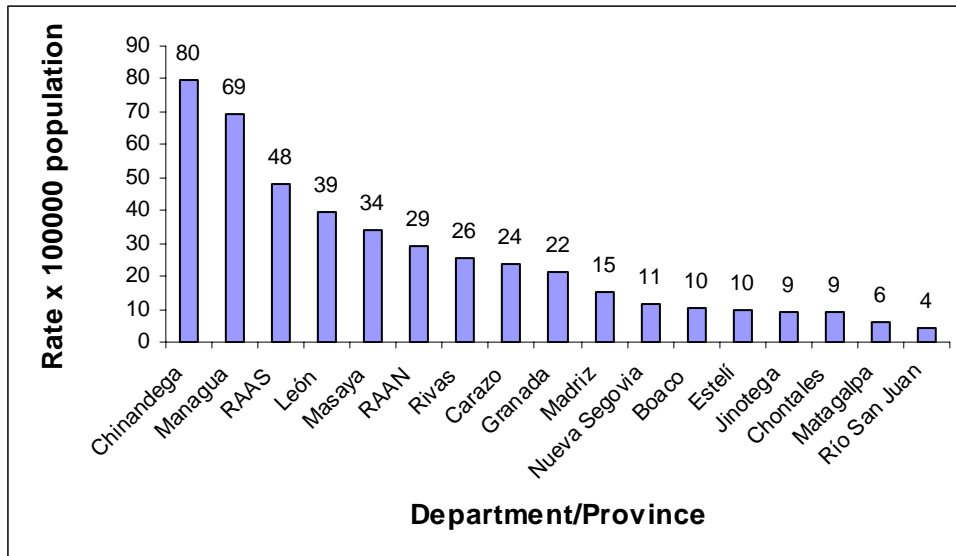
**Graph 1. HIV Reported cases by 100.000 inhabitants in Nicaragua, 1987-200**



Source: National HIV/AIDS Program

Estimates for 2003 indicated that the prevalence of HIV was around 0.2%.<sup>11</sup> Between 1987 and 2004, there were 1,402 reported cases of HIV, of which 97% were adults and 2% were children under 15 years. There were 7.6 cases per 100,000 population in 2005 – a rate 11 times higher than was observed in 1987 (0.66 cases per 100,000 population). Between 1987 and 2005, the male-female ratio went from 12.5:1 to 2.4:1, a reduction of approximately 80%.<sup>12</sup> As Graph 2 shows, the highest prevalence was observed in Chinandega (nearly 80 cases per 100,000 population), surpassing the rate observed in the capital city by about 11%. After Chinandega and Managua, the most affected regions were RAAs, León and Masaya, each with more than 30 cases per 100,000 inhabitants.

**Graph 2. HIV Prevalence Rate by Region 1987-2004**



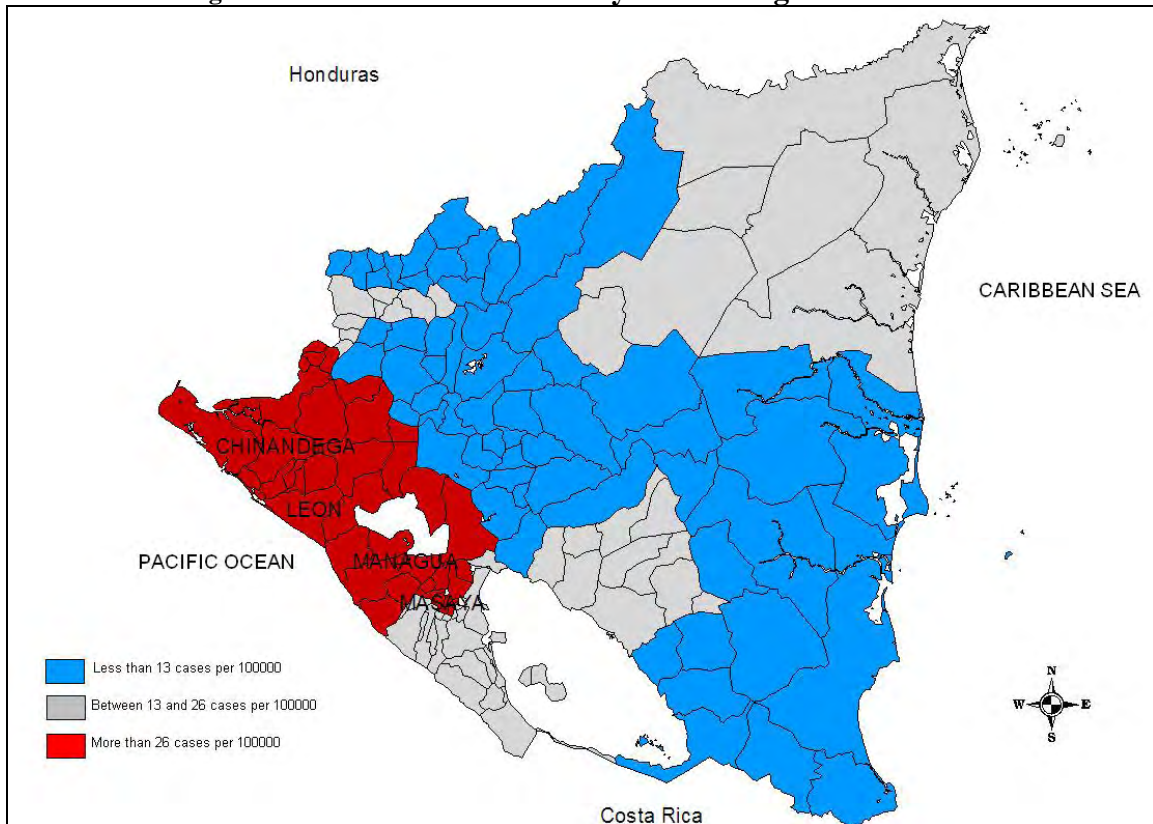
Source: National HIV/AIDS Program

Figure 1 shows the geographic distribution of HIV cases from 1987 to 2004. The map shows that the Northern and Central Pacific zones (e.g. Chinandega and Managua) were the most affected areas during 1987-2004. Nicaragua’s Atlantic zone cannot be overlooked, as prevalence rates have increased considerably in regions such as RAAS and RAAN.

<sup>11</sup> www.prb.org

<sup>12</sup> National STI/HIV/AIDS Program, 2004

**Figure 1: HIV Prevalence Rate by Health Region 1987-2004**

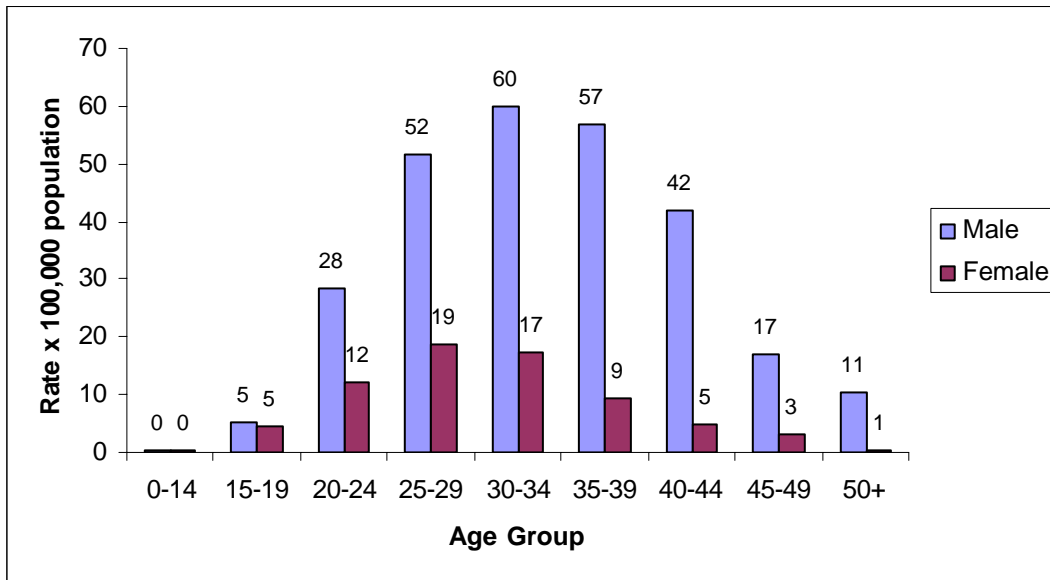


Source: National HIV/AIDS Program database and Centro Centroamericano de Población geographical data.

Graph 3 shows the number of HIV cases reported by sex and age for the 1987-1999 period. The greatest concentration of reported HIV cases was found in people 20-39 years of age. While the male-female ratio for cases in the 15-19 age group was almost 1:1, the ratio was 4:1 for the 30-34 age group, where the number of cases per 100,000 inhabitants was approximately 60.

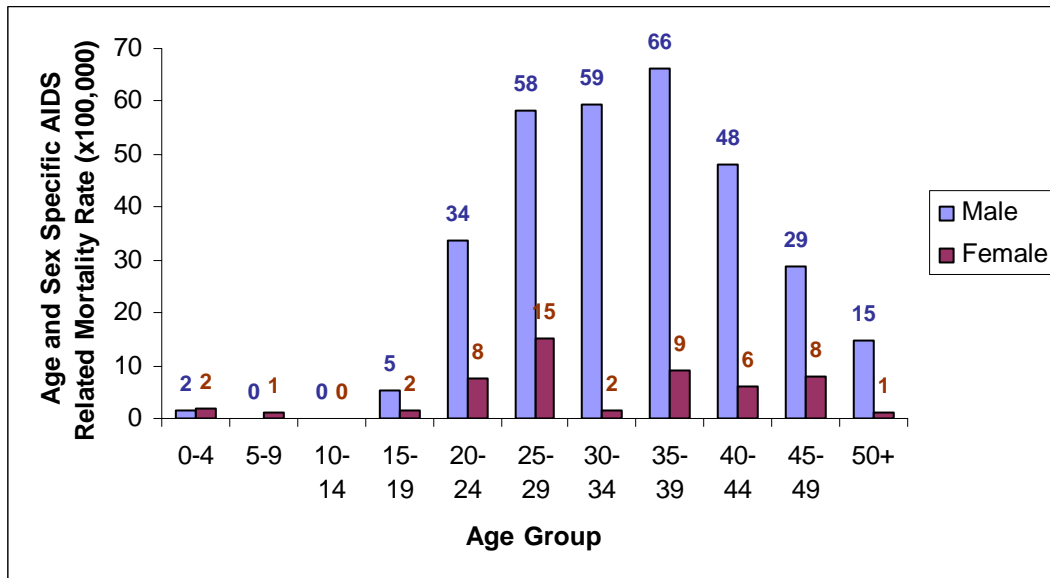
Graph 4 presents information on AIDS age- and sex-specific mortality rates. In the case of males, the highest mortality rates were observed in the 35-39 age group. In this group the male-to-female ratio of deaths per 100,000 was nearly 7:1. On the other hand, in the case of females, the highest mortality rates were observed in the 25-29 age group, where the male-to-female ratio of deaths per 100,000 was approximately 4:1.

**Graph 3. HIV reported per 100.000 inhabitants by Age and Sex in Nicaragua, 1987-1999**



Source: National HIV/AIDS Program

**Graph 4. Age and Sex Specific AIDS Mortality Rates, Nicaragua 1987-2004**

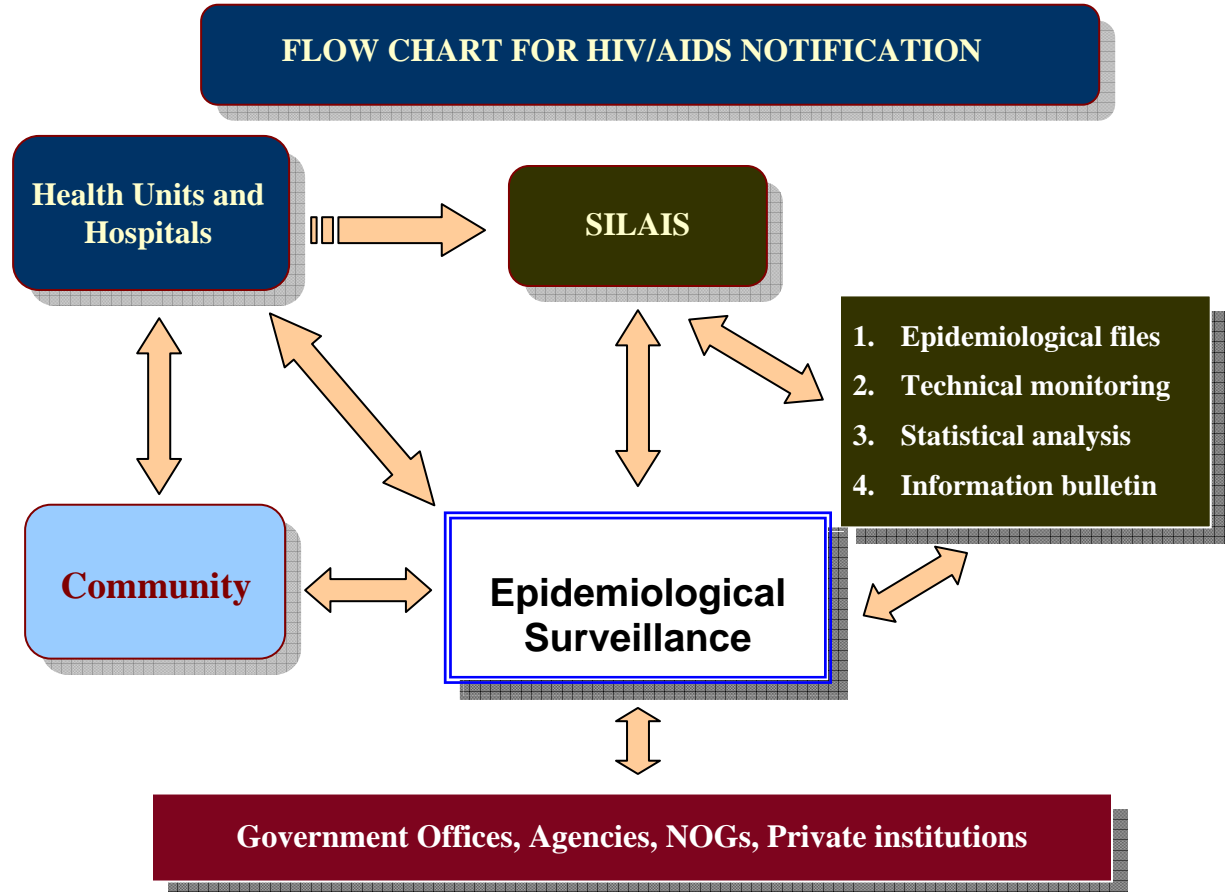


Source: National HIV/AIDS Program

The first AIDS case in 1987 fostered the creation of a registry of cases. One of the main challenges for the Epidemiological Surveillance System is to shift toward a second generation surveillance system that not only focuses on the general population, but also emphasizes different vulnerable groups and analyzes not only epidemiological data but also data related to people's perception, knowledge, attitudes and practices. The

following diagram shows the interaction of the main components of the Epidemiological Surveillance System for HIV and AIDS in Nicaragua (Figure 2).

**Figure 2. HIV/AIDS Case reporting process, Nicaragua 2005**



Source: National HIV/AIDS Program

### Vulnerable Groups

This section presents information on the different groups that are vulnerable to the epidemic, including HIV prevalence, location of these groups and their perceptions, knowledge and practices related to the epidemic.

**Sex Workers.** In 2003, HIV prevalence among sex workers was estimated at 1.7%.<sup>13</sup> Various factors such as extreme poverty, family disintegration, unemployment and lack of educational opportunities have driven many men and women to become commercial sex workers (CSW) in Nicaragua. Table 1 gives data on HIV prevalence among sex workers, according to UNAIDS estimates.

<sup>13</sup> UNAIDS, 2004

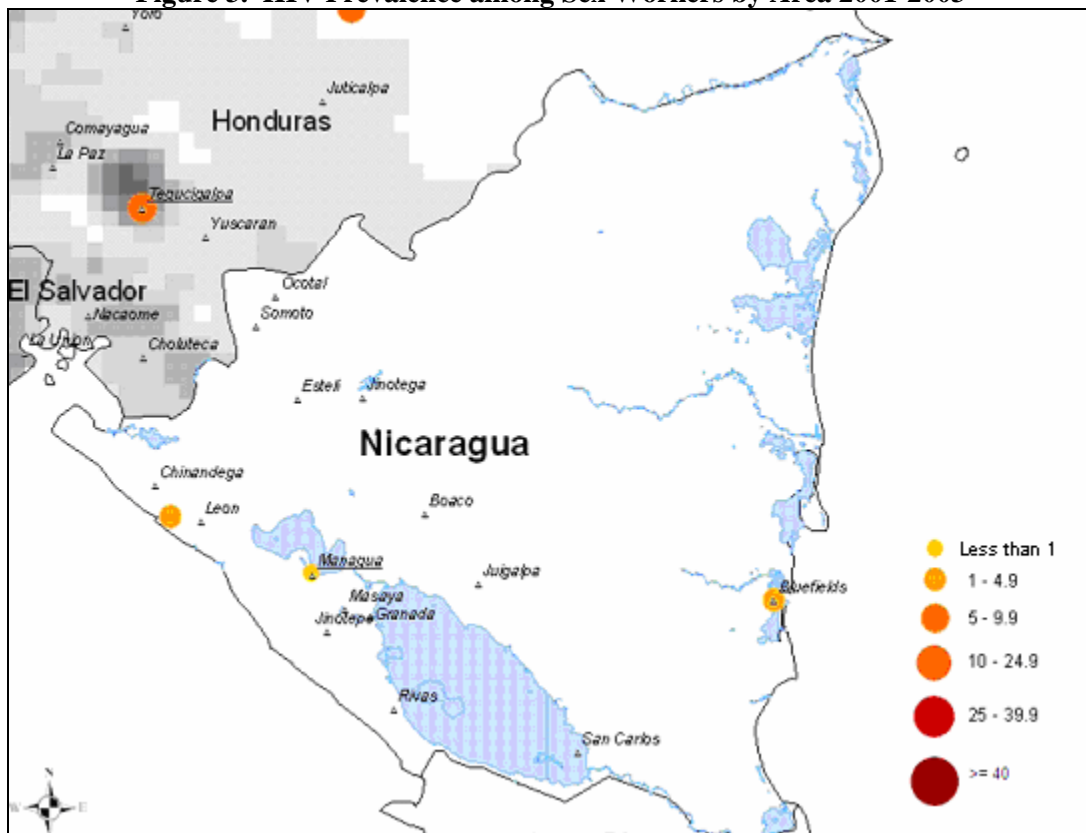
**Table 1. HIV/AIDS Prevalence in Sex Workers 1996-2003**

Year	Prevalence(%)
1996	0.3
1997	1.4
1998	N/A
1999	2.0
2000	N/A
2001	N/A
2002	N/A
2003	1.7

Source: UNAIDS

Figure 3 shows where this vulnerable group is most affected. As can be observed, the two most affected areas are the cities of Chinandega and Bluefields. In both cities, the prevalence of HIV is between 1% and 4.9%, higher than in the capital city (less than 1%).

**Figure 3. HIV Prevalence among Sex Workers by Area 2001-2003**



Source: Adapted from UNAIDS

The Central American Social Action Institute provided information on a 2002 multi-center study that measured knowledge and attitudes of sex workers about HIV/AIDS in

Nicaragua.<sup>14</sup> Some of the study findings are shown in Table 2. Data show that a high percentage of sex workers recognized the importance of using condoms (more than 80% in all locations). However, their responses may have been influenced by a desire to be “politically correct.” The data show that condom use was the only safe practice followed by the majority of interviewees.

**Table 2. Percentage of Sex Workers Practicing Safe Sex by Location 2002**

<b>Practice</b>	<b>Market</b>	<b>Streets/Bars</b>	<b>Nightclubs</b>
Condom Use	87.0	94.0	92.0
Only one partner (other than clients)	14.0	15.0	18.0
Do not use infected needles	12.0	14.0	18.0
Do not know about any safe practice	11.0	6.0	6.0

Source: ICAS 2002.

**Men who have Sex with Men.** In Nicaragua, organizations such as CEPRESI have carried out studies of men who have sex with men. In 1997, one of these studies found that HIV prevalence in MSM was approximately 1.2% (N=250). However, in 2002, the estimated prevalence for this vulnerable group was approximately 9.3%. Other results from 1997 also include the following: 98% of those interviewed had heard about HIV/AIDS, 86% recognized that condom use was a good practice for preventing HIV, and only 41% of those interviewed showed any desire to change their sexual behavior to reduce the risk of being infected HIV.<sup>15</sup>

**Prisoners.** A study from 2005 looked into HIV prevalence among prison inmates and staff in the Tipitapa Model Penitentiary. The sample was chosen from volunteers who decided to have HIV tests after receiving counseling (approximately 300 individuals). More than half of those interviewed stated they had not used condoms in their last sexual encounter. HIV prevalence among the study participants was approximately 1%.<sup>16</sup>

**Women.** During 1987-2004, 2.79 cases of HIV in men were registered for each woman. However, cultural and economic realities of Central America, and specifically of Nicaragua, make women more vulnerable to HIV. The need for many women to travel outside of the country to regions where the HIV epidemic has had a large impact creates conditions that increase the vulnerability of this population group.

**Vulnerable Youth.** The lack of educational opportunities and good information increase the vulnerability of Nicaraguan youth to the epidemic. Out of the total number of cases of HIV between 1987 and 2004 (N=1,402), 2% were minors under 15 years of age, and 3% of the people who died from AIDS (N=644) were in this age group.

**Orphans.** According to UNICEF estimates, in 2005 there were approximately 4,000 orphans in Nicaragua who had lost their parents to AIDS, representing 3.5% of all

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<sup>14</sup> ICAS 2002.

<sup>15</sup> PASCA, 1997

<sup>16</sup> National Police, 2006

orphans in the country. This figure is much higher than estimates of 100 in 1995 and 2,000 in 2001.<sup>17</sup>

***Indigenous Groups and Descendants of African Origin.*** According to the National HIV/AIDS Strategic Plan 2005-2009, HIV/AIDS prevalence in the Southern Atlantic Autonomous Region was approximately 47.1 per 100,000 in 2004, and 25.8 per 100,000 in the Northern Atlantic Autonomous Region that same year. Nicaragua is a multi-ethnic country. As a result, cultural realities differ from region to region. For example, the southern and northern Atlantic autonomous regions have the highest levels of illiteracy. They also are distinct because there is considerable religious influence on the sexual practices among their populations, especially among the Misquito. And because they are port regions, many of their inhabitants work on cruise ships, increasing their risk of being infected.

***Migrant Groups.*** In 2005, the Mexican Institute for Public Health sponsored a study on the impact of AIDS in mobile Central American populations.<sup>18</sup> In the case of Nicaragua, results for the Region of Rivas included:

- In 2001, most of the HIV cases reported were people who had caught the virus in another country.
- 94% of the 284 interviewees knew about the existence of STIs, and 71% knew STI symptoms.
- 99% of those interviewed knew about HIV and AIDS.
- According to information provided by the General Directorate for Immigration and Foreign Affairs, approximately 685,438 people crossed Nicaragua's southern border between 1996 and 1999. This is an underestimate of the number of people who actually crossed the border, but it is an indication of southern border activity, a probable HIV vehicle.

***People with Disabilities.*** According PAHO,<sup>19</sup> there are approximately 593,000 people with disabilities in Nicaragua – many as a result of the civil war. There is no information specifically on HIV/AIDS, though. In the Successful Experiences Workshop held in Nicaragua in May 2006, the issue of surveying the handicapped as a vulnerable group was addressed. The need for more research regarding coverage of services for preventing HIV in this population group is evident.

### **Perceptions of the Nicaraguan Population Regarding HIV/AIDS**

In 2003, PASCA and the Central American HIV/AIDS Prevention Project of AED/Futures did a survey sponsored by USAID/G-GA to measure public perceptions

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<sup>17</sup> UNICEF, UNAIDS, USAID. *Children at the Edge of the Abyss*, 2002

<sup>18</sup> Cuadra and Marsal, 2001

<sup>19</sup> PAHO. *Disabilities: What We All Should Know*, 2006

about HIV/AIDS among Central American adults.<sup>20</sup> The following are the most important findings from Nicaragua:

- 66% said they had heard much about HIV/AIDS, compared to 2.3% who said they had never heard anything about the disease.
- 40% agreed that people with HIV should not have access to public places.
- 60% agreed that sex workers with HIV deserve to have the disease due to their bad behavior.
- 99% agreed that information about HIV and AIDS should be handed out in schools
- 74% agreed that the owner of a company should have the right to ask a potential employee to take an HIV test as an employment requirement.

## The National Response to HIV/AIDS

Some of the main reference points are the following:

- In 1998, the National Program for the Prevention and Control of HIV/AIDS and Sexually Transmitted Infections was set up.
- In 1990, short and medium-term plans were developed.
- In 1991, the Sub-Regional Epidemiological Surveillance Workshop was held, which led to the adoption of the AIDS case definition suggested by PAHO.
- In 1996, Law 238 was enacted.
- In 1998, the National Strategic Plan (PEN) was proposed.
- In 1999, regulations were adopted and Law 238 went into effect.
- In 2000, the PEN was approved (Approval of the Transfusion Law, Reactivation of CONISIDA).
- In 2000, the Country Coordination Mechanism was established.
- In 2001, the second generation Regional Epidemiological Surveillance Workshop took place, and the Epidemiological Registry was modified.

This program is under the Health Ministry's General Direction for Health and Epidemiology. Its HIV/AIDS prevention, control and education services are carried out by local health systems together health clinics, first aid centers and regional hospitals. The National Program worked with other organizations to prepare a National Strategic Plan for the prevention of HIV and STIs. This plan defines eight priority cross-cutting strategies for facing HIV/AIDS and promoting a healthy behavior.

Another important element of the national response is the National HIV/AIDS Commission (CONISIDA), which was created by Law 238 (Law for the Promotion, Protection and Defense of Human Rights of PLWHA). Yet another element is the Country Coordinating

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<sup>20</sup> PASCA, USAID, Interdisciplinary Development Consultants (CID-Gallup) 2003

Mechanism (CCM), which was created in 2000 and whose members included representatives of six government institutions, two multilateral organisms, three NGOs, five educational organizations, one private sector entity, one religious group and one organization of PLWH.

## **LEGAL AND REGULATORY FRAMEWORK**

An effective national HIV and AIDS response must be based on an action plan that includes legislation, national guidelines and appropriate procedures for addressing various areas of the epidemic.

The Law for the Promotion, Protection and Defense of the Rights of People Living with HIV/AIDS was published in October 1996. As mentioned above, this law created the Nicaraguan HIV/AIDS Commission (CONISIDA) as an operative body which was to carry out its provisions. Also, the law contains provisions related to the rights and duties of PLWH. In the particular case of rights, this law has a number of provisions that protect PLWH, as described in Box 1.

### **Box 1. Articles Protecting the Rights of PLWH in Nicaragua**

- Article 5: Nobody can be forced to be tested for HIV without their consent.
- Article 7: HIV test results must be handled confidentially.
- Article 20: The authorities must guarantee the rights of all PLWH including those in prisons and psychiatric institutions.
- Article 22: PLWH have the right to work and carry out tasks commensurate with their abilities. Being HIV positive is not an acceptable reason for preventing a person from being hired or for terminating them.
- Article 24: PLWH and their children have the right to education.

In its fight against HIV, the Nicaraguan government adopted regulations for Law 238 in 2001. The legal framework of the response against HIV and AIDS is also supported by other laws and initiatives, as follows:

- Law 423 – General Health Law, which establishes the National Health System. This law ensures protection of the population against epidemics of any nature.
- Law 185 – Labor Code. This establishes that employers must guarantee the health of their workers at all times.
- The Safe Transfusion Law. This sets quality-control standards for blood donation, processing, conservation and transfusion processes.
- Law 28 on the Autonomy of the Atlantic Coast Regions. This law establishes how different administrative units handle health programs in these regions.

- The National Development Plan. This recognizes HIV and AIDS as a public health problem and calls for a rapid response.
- The National Health Policy. This establishes guidelines for creating a national program to contend with sexual and reproductive health issues.
- The National Education Policy. This recognizes the relationship between HIV and the lack of proper sexual education.
- The National HIV/AIDS and STIs Strategic Plan (2005-2009). This aims to coordinate national responses to HIV and AIDS while safeguarding the rights of PLWH.

This section describes the results of a PLWH discrimination survey, based on the UNAIDS Protocol to fight Discrimination.<sup>21</sup> The information was provided by personnel from the Xochiquetzal Foundation, a non-profit organization for preventing HIV and promoting the rights of PLWH.

*Health care.* Of the seven possible forms of discrimination involving health care recognized in the UNAIDS Protocol, only four occur in practice. These are: (1) differential treatment due to HIV status, (2) administering HIV tests without consent, (3) failure to inform a person regarding the results of his or her HIV test, and (4) lack of confidentiality. Evidence suggests that some cases of the first two forms of discrimination have occurred at national hospitals in Managua. Although the HIV/AIDS Law of Nicaragua expressly mandates confidentiality of test results, information obtained through Xochiquetzal suggests there have been a number of cases where confidentiality was breached at the Ministry of Health. In one case from 2000, for instance, the daughter of an HIV positive mother was placed in a cradle with a sign that read: “Isolated as she was born to an HIV positive mother.”<sup>22</sup> No evidence was obtained concerning denial of treatment due to a person’s HIV status, or compulsory reporting of the person’s HIV status to the sexual partners or spouse.

*Employment.* Of the seven possible forms of employment-related arbitrary discrimination, five occur in practice. These include: (1) compulsory tests before a person is hired; (2) compulsory tests while a person is employed; (3) lack of confidentiality; (4) termination due to HIV status; and (5) denial of employment on grounds of a person’s HIV status. Evidence provided by Xochiquetzal points to cases of the first two forms of discrimination in sugar cane mills in Chinandega, the department that is most affected by HIV in Nicaragua. Cases involving lack of confidentiality were detected in a high school in Tipitapa as well as in the Leon Hospital and in commercial establishments in Chinandega. Evidence provided by Xochiquetzal did not mention cases in which employees were terminated on the basis of their serologic status. No information was obtained regarding questions about an individual’s serological status on employment interview forms, or restrictions regarding promotions and employment benefits due to the employee’s serological status.

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<sup>21</sup> UNAIDS 2000.

<sup>22</sup> LA PRENSA. December 2, 2000.

*Judicial/Legal Processes.* Of four different forms of arbitrary discrimination analyzed in this area, only one was reported to occur in practice. It involves differences in verdicts and sentences based on HIV status. According to evidence provided by Xochiquetzal, this type of discrimination is allowed by law and internal procedures. For example, Article 195, paragraph 6 of the Criminal Code establishes that the penalty for the crime of rape is 15 to 20 years in prison. A list of aggravating circumstances for this crime includes Clause 6 of Article 195 of the Criminal Code of Nicaragua: “When the author is a carrier of a serious illness transmissible through sexual contact.”

Although it was not stated whether practices such as sex work and homosexuality are prosecuted as criminal acts in practice, these behaviors are criminal offenses under current laws. For example, Article 204 of the Criminal Code in Nicaragua states that sodomy is committed by “anyone who induces, promotes, propagates or scandalously practices concubinage with people of the same sex.” The punishment for such an offense is one to three years of prison.<sup>23</sup> No information was obtained related to specific criminal offenses in the event of deliberate transmission of HIV.

*Public Administration.* There is no information that any of the five possible forms of arbitrary discrimination explored in this area occur in practice. It was reported that arbitrary discrimination occurs in practice in this area, particularly in compulsory tests that are required as a condition for entering the country. There is also evidence of discrimination in connection with applications for scholarships for studying in the United States. No information was obtained concerning deportation on the basis of a person’s HIV status.

*Social Welfare, Housing, Education, Family Life and Reproductive Health.* There is no information or evidence related to this area.

*Other Public Institutions.* Information provided suggests that PLWH face restrictions in practice on their access to public institutions such as public transportation.

*Insurance and Other Financial Services.* Of the three aspects included in this area, the only type of discrimination reported involved denial or restrictions on acquiring insurance due to HIV status. National insurance agencies required tests for people seeking life insurance.<sup>24</sup>

Annex 3 summarizes the findings and evidence concerning discrimination.

*Response to Arbitrary Discrimination.* Some cases suggest that discrimination occurs in violation of Nicaraguan law. In July 2000, a group of PLWH activists confronted the Health Ministry authorities regarding enforcement of the HIV/AIDS law. The activist group, called Nicaraguan Association of PLWHA (ASONVIH/SIDA), declared that four of its members had died because the government was unable to provide them proper

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<sup>23</sup> Article 204 of the Criminal Code of Nicaragua

<sup>24</sup> (Pacific Insurance) *Seguros del Pacífico* and *INISER*

treatment. This situation demonstrated that the law lacked important definitions. For example, a Central American comparative analysis made by the Honduran National Human Rights Commission (CONADEH)<sup>25</sup> found that the Nicaraguan as well as Honduran law only make a general reference that PLWH should be provided treatment, and do not specifically define the details of the treatment that should be provided.

Various proposed provisions of the National HIV/AIDS Strategic Plan 2005-2009 suggest that a significant number of PLWH and public employees in the education and health sectors are not aware that the law exists or that it protects certain human rights. Ignorance of the laws and the basic rights they protect creates an environment that promotes discrimination. The plan's preliminary sections state that the Ethics Committee from CONISIDA – the body supposedly handling cases of PLWH whose rights have been violated, as proposed in the HIV/AIDS law, is not in operation. This situation was confirmed by participants of the workshop held in Managua in May 2006 in order to discuss successful HIV and AIDS response experiences in Central America.<sup>26</sup>

A study conducted in 2004 by GTZ, a German cooperation agency, found that although the existence of Law 238 represented a step forward in providing PLWH legal protection, the law had not been properly implemented. The authors of the study noted that Law 238 gave PLWH the right to receive full and adequate treatment, but that Nicaragua is one of the few countries in Latin America where antiretroviral therapy is available for very few people and that the country discriminates against most PLWH. Consequently, it is not surprising that the most frequent complaints from PLWH involve a lack or inadequate treatment and marginalization.<sup>27</sup>

Annex 5 of the UNAIDS Protocol on Arbitrary Discrimination raises certain issues about efforts to protect human rights of PLWH so that the kind of cases described in the previous section can be prevented. The study shows the following:

- Regarding the existence of communication campaigns or forums that encourage the fight against discrimination, Nicaragua's National Strategic Plan for 2005-2009 serves as an agreement and framework for coordinating the national response to HIV and AIDS. It also serves as a starting point for protection of the rights of PLWH. Among its many aspects are provisions on the protection of human rights, prevention efforts and raising awareness regarding the epidemic. Concerning educational and information campaigns to fight discrimination for the past two years, in September 2005, the Regional Network of Human Rights and HIV/AIDS held a meeting in Montelimar, Nicaragua. The conference included an educational component related to following up human rights violations, educational sessions

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<sup>25</sup> CONADEH/UNDP – Compliance with the Special Law on HIV/AIDS in Honduras and comparison with the HIV/AIDS Law in Central America and Panama,” Tegucigalpa, 2003

<sup>26</sup> HIV/AIDS related stakeholders from the governmental, non-governmental and international cooperation sectors.

<sup>27</sup> Piechulek H, Mendoza Aldana J., German Agency for Technical Cooperation (GTZ), Managua, Nicaragua. “Stigma and Discrimination towards HIV/AIDS in Nicaragua.” Int. Conf. AIDS 2004 Jul 11-16; 15.

regarding the procedures for protecting human rights and workshops with PLWH representatives.

- Regarding whether there are non-profit organizations in charge of promoting the principle of non-discrimination, two institutions should be mentioned: The Ombudsman's Office and the Nicaraguan Center for Human Rights (CENIDH). Since its founding in 1990, the latter group has concentrated on promotion and defense of human rights. Its activities include educational campaigns throughout the country, the operation of a network of human rights promoters and the investigation of cases related to human rights violations.
- Regarding whether there is an organization whose main objective is to support and defend the rights of PLWH, an association called the Nicaraguan Association of people PLWHA (ASONVIH/SIDA) was created to defend the rights of PLWH in Nicaragua. Additionally, this organization carries out activities related to helping people obtain appropriate treatment, fostering experience sharing and raising HIV and AIDS awareness among the population. The UNAIDS Protocol also asks whether the organization has the right to appeal or present cases in court. In the case of ASONVIH/SIDA it is important to say that it may provide legal counseling and with the support of institutions such as CENIDH and the Xochiquetzal Foundation, it has the capacity to take these cases to the pertinent court.

#### **PREVENTION AND CARE FOR VULNERABLE GROUPS**

This section provides information on successful HIV and AIDS-related experiences by the Ministry of Interior and the Xochiquetzal organization. There are parallels between Xochiquetzal's Integrated Attention Program and the AIDS Prevention and Control Program implemented in the Dominican Republic in 1995. Both initiatives involve major efforts to disseminate health promotion and HIV prevention messages.

#### ***Nicaragua: Commitment and Action in the Face of AIDS, TB and Malaria –HIV/AIDS Component.***

The program is directly based on the National Strategic Plan, which calls for IEC to promote the prevention of HIV and safe sex practices. The program also fulfills the mandate established by the National Strategic Plan concerning care that at risk groups (in this case mobile populations and prison inmates) should receive.

In 2003, the Country Coordinating Mechanism obtained funding from the Global Fund for the "Nicaragua: Commitment and Action in the Face of AIDS, Tuberculosis and Malaria" Project. The total cost of the project was US \$18 million, of which US \$10 million was for the AIDS component. In accordance with its criteria for selecting and awarding donations, the Global Fund designated the *Nica-Salud Network Federation* to be the primary recipient to handle and administer the grant. The primary recipient may, under this agreement, provide funding for other entities to carry out activities included in the program. The Ministry of Interior is a sub-recipient. The Ministry signed a sub-

agreement with Nica-Salud Network in 2004, and was assigned a total of US \$230,600 for the first year of activities.

The Ministry of the Interior is the supervisory institution for various agencies, including the Immigration Office, the National Firefighter Force and the Civil Police Force. Its primary goals include providing the necessary foundations for securing the safety and guaranteeing the rights of the people. The Ministry carried out the project through its Directorate of Prevention and Social Assistance (DPAS), which is part of the new General Directorate of Citizen Security and Coexistence, which promotes prevention, care, values based on codes of healthy behavior, guardianship of human rights and citizen security, and takes steps to ensure compliance with Law 238 and non-discrimination of PLWH.

The general goals of the HIV/AIDS component are as follows:

- To prevent new cases of HIV and other STIs through IEC.
- To prevent and control new cases of sexually transmitted infections.
- To ensure integrated attention for Nicaraguans living with HIV.
- To ensure proper recording of HIV and AIDS cases and monitoring of risky behavior.
- To strengthen local and central multi-sector coordination.
- To promote human rights as a tool for HIV prevention, ensuring non-discrimination of PLWH.

The program addresses national issues regarding the epidemic. For example, in Nicaragua there is still a considerable lack of knowledge about Law 238 on HIV/AIDS. Accordingly, one of the strategies of the program involves efforts to promote knowledge about this law among prisoners and Ministry authorities. The program also aims at creating awareness about the need for adequate care for PLWH, especially in the workplace, through clinic networks.

*Results.* Below is a description of the activities developed to meet the proposed goals and strategies, and program achievements.

Strategy 1. Design and implement an IEC plan for prevention of STIs and HIV.

- 42 high-level officials received training: the Minister, the Vice-Minister, the General Secretary, general directors and specific directors, special guests from CONSIDA and others.
- 34 participating leaders received training to provide support for future base promoters.
- Training for 75 base promoters from within all areas of the institution.

- Purchase and distribution of 12,000 condoms by the Direction of Prevention and Social Assistance. The condoms were distributed in training sessions with prison inmates and also during the baseline research on mobile populations.
- Elaboration of a website and pamphlets that were issued listing relevant national and international information on the epidemic, as well as an edition of the journal InfoSida, an active and permanent presence in the television program and journal ‘Visión Policial’ and production of the play “Virus Immersed in Humanity.”
- Strategy 2. Train health personnel of the Ministry of Interior on HIV prevention and STI syndromic management
- 4,708 prison inmates were trained on HIV/AIDS in 47 workshops in seven penitentiary systems.
- A workshop was conducted with participation of all sectors of the Carlos Roberto Huembes Hospital, 16 clinics under the National Police, seven clinics in the National Penitentiary System, (excluding the RAAS, since it does not have an assigned doctor), and staff from the Direction of Immigration and Foreign Affairs, Direction of Firefighters and Central Activities clinics.
- Workshops on bio-safety were conducted for selected groups such as the Carlos R. Huembes Hospital, National Police clinic, Direction of Firefighters, National Penitentiary System, Immigration and Foreign Affairs and Central Activities.
- 500 Human Resource staff trained in bio-safety, establishing 150 bio-safety regulations and training 3,929 literate prison inmates regarding STDs/HIV/AIDS.
- Condoms distributed by doctors from clinics throughout the country’s prisons. In addition condoms were distributed to military in different areas of the country.

### Strategy 3. Strengthen the surveillance system for STIs and HIV/AIDS

- Implementation of a surveillance network consisting of a server that is networked to three locations at the Carlos Roberto Huembes Hospital
- Staff training in second generation and sentinel site surveillance, training also for statistics and health personnel at National Police and National Penitentiary System clinics.
- Volunteer social service (“Together against AIDS”) instituted by a ministry mandate. The achievements of the Volunteer Social Service include:
  - Establishment of an Integrated Program for HIV and AIDS at job sites.
  - Support of the national HIV/AIDS Program through the institutionalization of a new employment policy guideline.
  - 100% of the working population (11,000 people) of the Ministry (MIGOB) trained in risk perception.
  - 60% of the military/police and 80% of literate prison inmates trained in HIV/AIDS risk perception, prevention mechanisms and transmission.
- Indicator for number of samples taken and processed, 2 sentinel sites in operation.

- Through the Hospital Reference Program, a second generation surveillance system was improved at clinics in Tipitapa. In addition, sentinel sites created in the Penitentiary System and the Carlos Roberto Huembes Hospital.
- At sentinel sites, a total of 2,600 samples have been taken for rapid testing. 600 samples showed an HIV prevalence of 0.5%. The goal of obtaining 2,700 samples and excluding 10% of the control tests was not met due to delay in obtaining reagents.

Strategy 4. National prevention policies, promoting human rights and ensuring equality before the law for PLWH and non-discrimination

- A total of 151 employees received extensive training regarding Law 238. 1,800 other people were provided information on Law 238 and sensitized as part of the exercise within the workshop for training promoters.
- Approximately 350 high-level police officers were informed of Law 238 and 40 high-level officials in the department of Managua and its eight municipalities were trained.

Strategy 5. Promotion and Public Defense of Law 238.

- Through the Office of Care and Social Assistance (DPAS) and allies from the civil sector, Law 238 was promoted and disseminated.

#### *Future Plans and Priorities*

- Training for prison inmates.
- Training in syndromic management for STIs
- Training in bio-safety
- Copying and distributing IEC materials
- Purchasing and distributing ART for PLWH
- Purchasing and distributing bio-safety materials and standards
- Purchasing and distributing non-medical materials for Integrated care of PLWH in the HCRH (Carlos R. Huembes Hospital)
- Training in promoting public defense with an emphasis on Law 238
- Management capacity building
- Evaluating management and project results.

#### ***Xochiquetzal Foundation's Integrated Care for PLWHA Program.***

Xochiquetzal is a non-governmental organization founded in 1990 that works in both urban and rural areas. The organization was founded by a gay/lesbian movement, and conducts IEC initiatives related to HIV and other sexually transmitted diseases. Beneficiaries of the program include not only highly vulnerable groups (men who have sex with men, sexual workers, prison inmates), but also groups such as children at risk of exploitation and officials of local public institutions, who help raise awareness about HIV and AIDS.

In general, the program has considerably influenced the implementation of the national HIV/AIDS strategic plan, which guarantees coordination between the Foundation's actions and program and the new strategic plan for 2005-2009. The Xochiquetzal Foundation has contributed to the inclusion of children at risk of sexual exploitation as a vulnerable group in the National Strategic Plan, and to the promotion of community participation in the fight against the epidemic.

The Integrated Care for PLWHA Program began in 1992, with the primary goal of guaranteeing that PLWH receive health care, prevention, treatment, and legal protection. The program began in Chinandega, the Region with the highest HIV prevalence in the country, and then was expanded to the Regions of Matagalpa, Estelí, Nueva Segovia, Jinotega and Madriz. Activities were carried out by Xochiquetzal's central staff, which consists of two doctors, two laboratory workers, two psychologists and two lawyers, with the support of the foundation's administrator and technical director as well as local counterparts. The establishment of an integrated care clinic for HIV/AIDS is envisioned for the future. In addition, proposed reforms are planned for the current Law 238 on HIV/AIDS. The program is also working to get other local units to follow the proposed integrated care model. The program has three clearly defined components:

1. Education: This component includes a telephone counseling service called "*Línea con vos*" ("On the Phone With You"), radio programs and publication of a quarterly magazine called "*Fuera del Closet*" (Out of the Closet).
2. Communication
3. Integrated care (health, psychological support and legal counseling)

The main funding sources have varied over the years (Table 3). One of the most important has been the Norwegian cooperation agency, NORAD. Other funding sources include the Swedish Agency for International Development (SIDA), the European Economic Community (EU), the Dutch Embassy and HIVOS. The HIV/AIDS component for civil volunteer groups received 489,515 euros from the European Union for a four-year implementation of the project.<sup>28</sup>

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<sup>28</sup> European Commission in Nicaragua, Costa Rica, El Salvador, Honduras, Guatemala and Panama. List of projects underway in Nicaragua.  
[http://www.delnic.cec.eu.int/es/eu\\_and\\_country/cooperation\\_list/cooperation\\_list\\_nic.htm](http://www.delnic.cec.eu.int/es/eu_and_country/cooperation_list/cooperation_list_nic.htm)

**Table 3. Funding of the Integrated Attention Program (US\$)**

Organization and Period	Human Resources	Equipment	Material and Reagents	Drugs	Condoms	Total
NORAD 1992-2005	159,982.00	4,677.00	26,582.21	18,661.73		209,902.94
SIDA 1993-1996	4,021.00	4,181.00	-	-	-	8,202.00
HIVOS 1994-2005	60,840.00	1,590.00	-	-	-	62,430
DUTCH EMBASSY CR 1992-2002	43,723.00	-	-	-	-	43,723.00
DUTCH EMBASSY NY 2005-2008	16,738.00	23,500.00	13,300.00	5,310.00		58,848.00
EU – GVC 2002-2004			16,800.00	21,050.00	76,975.00	114,825.00
EU – GVC 2002-2005	23,360.00	42,100.00	41,969.00	9,970	11,833.00	129,232.00
<b>TOTAL</b>	<b>308,664.00</b>	<b>76,048.00</b>	<b>98,651.21</b>	<b>54,991.73</b>	<b>88,808.00</b>	<b>627,162.94</b>

Source: Xochiquetzal Foundation, 2006

*Results.* There is much evidence of the success of the Xochiquetzal Integrated Healthcare Program:

- Xochiquetzal cares for 29% of the total number of people receiving antiretroviral treatment in Nicaragua.
- The program has measured prevalence in the populations it covers, confirming that Health Ministry estimates are conservative. According to a seroprevalence study executed in 2005, for example, out of 1,090 people seen by the program, 2.1% were HIV-positive; in 2004 the figure was 2.3%. These compare with Health Ministry estimates of less than 0.5%.
- A total of 280,360 people were recorded as benefiting from the education component in 2000-2004: 330 MSM, 175 lesbians, 6,573 prison inmates, 26,116 secondary school students and 206,985 neighborhood and community residents received information on HIV and AIDS.
- A total 17,449 people health services from the integrated care component in 2000-2004. Details included 5,956 doctor's office visits, 3,120 psychologist's office visits, and 12,800 laboratory tests.
- 435,708 people benefited from the communications component.

*Communication of HIV Prevention Messages Directed at Ethnic Groups.* Article 4 of the Nicaraguan legislation states that the media must disseminate scientific and reliable data related to the prevention of HIV. According to the National Strategic HIV/AIDS Plan (2005-2009), the national Information, Education and Communications (IEC) strategy focuses on conveying basic knowledge about HIV and AIDS and HIV transmission. Currently, educational information is available in magazines, pamphlets and posters, including some in English for the afro-descendent community and some in the Misquito language for people living in the autonomous, Atlantic regions of the country.

*Condoms.* According to information by the Latin American HIV/AIDS Initiative (SIDALAC), condom expenditures totaled US\$ 1.8 million in 2003. Approximately 62% of this amount came from private sources, and the rest from foreign sources.

## TREATMENT

During 2004, according to PAHO, nearly 10% of the people who needed ART received medication (N=311).<sup>29</sup> Protocols for preventing vertical transmission have been in place in Nicaragua since 2000. According to the National HIV/AIDS Program, ART was initiated in 2003 at the Roberto Calderón and Bertha Calderón Hospitals and La Mascota Children's Hospital with 13 patients. By 2005, 200 patients were on ART. The Nuevo Amanecer, Ernesto Sequeira, España and HEODRA Hospitals also began to provide treatment. Table 4 shows the treatment regimes in use.

The main source of funding for treatment is the Global Fund. For 2005-2006, this institution granted US\$ 335,336 to Nicaragua. Approximately US\$ 34,200 of that amount was used for the purchase of reagents.

**Table 4. ART Regimes in Nicaragua, 2005**

No	Scheme Name	No	Scheme Name
1	Combivir + Efavirenz	10	Combivir + Abacavir
2	3TC+D4T+ Nevirapine	11	D4T +DDI + Efavirenz
3	3TC+D4T+ Efavirenz	12	DDI + Efavirenz+Abacavir
4	Combivir + Ritonavir\Indinavir	13	DDI + 3TC+Nelfinavir
5	3TC+D4T+ Ritonavir\Indinavir	14	DDI + 3TC+Ritonavir\Indinavir
6	AZT +3TC+Ritonavir	15	D4T +3TC + Abacavir
7	Combivir + Nevirapine	16	AZT +DDI+ Efavirenz
8	Combivir + Nelfinavir	17	DDI+3TC+Nevirapia
9	D4T +DDI +Ritonavir\Indinavir		

Source: National STIs and HIV/AIDS Program

In Nicaragua, the Directorate of Food and Medicine Regulation is in charge of regulating medicines and medical supplies for HIV/AIDS and opportunistic infections. It is part of the Health Ministry according to regulations established under Law 290. Among its primary duties are to:

1. Guarantee supervision and inspection of manufacturers, distributors, wholesalers and retailers of medical supplies
2. Oversee the quality and adequacy of materials and promotional and advertising activities for medicines and cosmetics
3. Ensure the quality of medicines through qualitative and quantitative analyses
4. Establish registration requirements and standards and procedures for pharmaceutical products, chemical substances, and health establishments and professionals
5. Evaluate imports and exports of pharmaceutical products and chemical substances and either approve or refuse them based on its evaluations.
6. Authorize and issue permits for establishments selling medicines provided they comply with legal requirements

<sup>29</sup> PAHO/WHO Fact Sheets Regarding Prevention and Treatment, 2004

7. Supervise and guarantee proper registration and legalization of medicines by means of effective product evaluation and control
8. Record and update registries of authorized medicines and establishments

ARV are purchased by the Office for Regulation of Medical Supplies (DNIM). The requirements for registering medicines for HIV are established in Law 292 and its regulations.<sup>30</sup> These requirements apply to the marketing of all medicines in the country. Other requirements for registering medicines include: (1) that the pharmaceutical establishment be legally registered at the Office of Accreditation and Regulation of Food and Medicines, (2) that the request for requiring medications be made in writing (typewritten) on legal paper with a fee of three cordobas (US\$0.16) signed by the legal representative and pharmaceutical regent of the establishment, and (3) that the request be drawn-up, evaluated and presented by the pharmaceutical regent.

Since Nicaragua does not have a pharmaceutical industry that produces ARV drugs, these must be imported by distributors and other medical importers, provided that the product has a health registration certificate. Products are sold by medicine distributors/importers to authorized private pharmacies or to the Ministry of Health through bidding processes. Purchases are carried out with assistance from the following agencies:

1. PAHO: Purchases from PAHO are requested through the Purchasing Unit of the Ministry of Health (MINSa).
2. The Global Fund: Through a purchase plan elaborated in coordination with the National HIV/AIDS Program.

Drugs and reagents are purchased on an annual schedule, and are distributed quarterly. The total number of PLWH who meet the clinical, viral and immunological criteria are taken into account when the annual plan is developed. There are no distinctions between planning for the general population and vulnerable groups. The purchase of laboratory tests is programmed through the coordination of different health units.

A number of questions remain concerning the purchase of ARV medicines, including:

- (1) There is no specific information regarding storage of medicines that are purchased, or on the distribution of medicines in local areas.
- (2) More information is needed on the probable effect of CAFTA-DR on medicine purchasing.

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<sup>30</sup>Chapter II, Articles 8-19 of the Law for Medicines and Pharmacies and Chapter IV, Articles 10-26 of the regulations

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## **ANNEX 1. FORM FOR EVALUATING DISCRIMINATION**

### **Questions relating to UNAIDS Annex 5**

- 1) Are there agreements or communications forums that fight against discrimination?
- 2) Are there agencies for defending human rights?
- 3) Is there an NGO whose objective is defending the human rights of PLWH?
- 4) What is the degree of coordination among the agencies that defend human rights?
- 5) Are there information and educational campaigns directed at fighting discrimination?

### **People Interviewed Regarding Discrimination**

- Fernando Cano, PASCA, Guatemala
- Janeth Flores, National Commission of Human Rights ( Comisión Nacional de Derechos Humanos), Honduras
- Alexia Alvarado, PASCA and President, Alliance for Legislation (Alianza para la Legislación), El Salvador
- Karla Aburto, VIH-AIDS Advisor, UNFPA, Nicaragua
- Eda Quirós, Head of Health Human Resources, Ministry of Health, Costa Rica
- Maite Cisneros, Ombudsman, Panama

**ANNEX 2. FORM FOR SELECTING SUCCESSFUL INTERVENTIONS**

<b>Name of the Institution:</b>	
<b>Participation:</b> <input type="checkbox"/> Program <input type="checkbox"/> Project	
<b>Country:</b>  <b>Region:</b>  <input type="checkbox"/> Urban <input type="checkbox"/> Rural	<b>Type of activity addressed:</b> <input type="checkbox"/> Prevention <input type="checkbox"/> Treatment <input type="checkbox"/> Mitigation of Damage <input type="checkbox"/> Legal actions in defense of human rights <input type="checkbox"/> Gender <input type="checkbox"/> Other (Please indicate):
<b>A. GENERAL INFORMATION OF THE ORGANIZATION THAT IS CARRYING OUT THE SUCCESSFUL EXPERIENCE</b>	
<b>1. Type of Organization:</b>  <input type="checkbox"/> Community Organization <input type="checkbox"/> Non-governmental organization <input type="checkbox"/> Governmental Organization <input type="checkbox"/> Private Sector <input type="checkbox"/> Associations <input type="checkbox"/> Other (Please indicate):	<b>2. Year it was established:</b> <input type="text"/>  <b>3. Description of the Organization:</b> Background Objectives Personal

<b>B. INFORMATION ABOUT THE PROJECT-PROGRAM</b>	
<b>Name of the Project:</b>	
<b>1. Type of activity Addressed:</b>  <input type="checkbox"/> Prevention <input type="checkbox"/> Testament <input type="checkbox"/> Mitigation of the damage <input type="checkbox"/> Legal actions in defense of human rights <input type="checkbox"/> Gender <input type="checkbox"/> Other (specify):	<b>2. Year it initiated:</b> <input type="text"/>  <b>3. Year it ended:</b> <input type="text"/>  <b>4. Description of the Project:</b> Historical Background Objectives Personnel

<b>5. Population Benefited:</b>	
<input type="checkbox"/> Commercial Sex Workers	<input type="checkbox"/> Prison inmates
<input type="checkbox"/> Indigenous groups and Afro-descendants	<input type="checkbox"/> Vulnerable Youth
<input type="checkbox"/> Men who have sex with other men (MSM)	<input type="checkbox"/> Orphans
<input type="checkbox"/> Migrant groups in affected regions and direct victims of the epidemic	<input type="checkbox"/> Businessmen
<input type="checkbox"/> Military and Police	<input type="checkbox"/> Manufacturing Plant Employees
	<input type="checkbox"/> Other (specify):
<b>6. Sources of Finance:</b>	
<b>7. Reasons explaining why it is considered a successful experience:</b>	
<ul style="list-style-type: none"> <li>• Impact</li> <li>• Coverage</li> <li>• Access</li> <li>• Particular characteristics, innovation, permanence, methodology.</li> </ul> <p>This data must contain qualitative, quantitative and demonstrative success indicators. Files, pamphlets, samples of work can be attached.</p>	
<b>8. Future Perspectives of the Project</b>	
<b>9. Relationship to the Strategic Plan of the Country Regarding AIDS</b>	
<b>10. Sources of Finance.</b>	
<b>11. Relationship to the AIDS problem. What is the relationship does the dimension and severity of the HIV/AIDS problem have in the country?</b>	

### ANNEX 3. FINDINGS AND EVIDENCE OF THE DISCRIMINATION SURVEY, NICARAGUA 2006

Area	Findings	Evidence
<b>Health Aid</b>		
HIV testing without patient's knowledge	Occurs in practice	Differential treatment is given in national referral hospitals located in the capital.
Differential treatment due to HIV/AIDS status	Occurs in practice	Differential treatment is given in national referral hospitals located in the capital. (i.e., case published in the newspaper <i>La Prensa</i> in 2000 – Mother and newborn daughter segregated in Bertha Calderón Hospital)
Lack of confidentiality: informing others of the names of people proven to be HIV-positive, or allowing, consciously or through neglect, confidential files to be consulted	Occurs in practice	Case of mother and infected daughter whose condition was disclosed in the neighborhood where the person lived. Bertha Calderón Hospital
Refusal to inform a person of his or her HIV test results	Occurs in practice	Red Cross case
<b>Employment</b>		
Compulsory testing before hiring	Article 5 of the HIV/AIDS Law stipulates that no one can be tested for HIV antibodies without his or her knowledge and express consent. But this occurs in practice.	Cases detected in sugar mills in the Chinandega Region
Compulsory testing while on the job	Article 5 of the HIV/AIDS Law	Cases detected in sugar mills in the Chinandega Region and banks
Lack of confidentiality with respect to HIV/AIDS status	Confidentiality is required by law. However, violations occur in practice.	Case of commercial establishments in Chinandega
Firing or changes in employment conditions due to HIV/AIDS status	By law, an employee cannot be fired due to his or her HIV/AIDS status. However, this occurs in practice.	High school case in Tipitapa, Nurse's case published in <i>La Prensa</i> in 2005

Continued on next page

<b>Justice/Legal Proceedings</b>		
Classifying behavior (such as sexual relations between men) as a crime	Stipulated by law. However, this occurs in practice.	Article 204 of the Criminal Code: Anyone inciting, promoting, propagating or practicing unnatural coitus between people of the same sex will be guilty of committing the crime of sodomy and penalized with one to three years of prison. This article is subject to potentially discriminatory interpretations.
Differential sentencing and/or penalties due to HIV/AIDS.	Stipulated by law.	Article 195, clause 6 of the Criminal Code: Anyone using force, intimidation or any other means depriving another person of their will, reason or sense in order to have carnal access to that person, or who introduces any organ, instrument or object into that person for sexual purposes, shall be guilty of committing the crime of rape. The perpetrators and victims of this crime may be people of either sex. The penalty for the crime of rape will be 15 to 20 years in prison. Drunkenness or drug addiction will not be considered extenuating circumstances. The following are aggravating circumstances for this crime, without affecting the contents of the following clauses in Article 30 Clause 6: When the author is a carrier of a serious illness transmittable through sexual contact.
<b>Insurance and Other Financial Services</b>		
Life insurance contract denial or restrictions due to HIV/AIDS status or because a person belongs to a group considered at high HIV risk	Stipulated by internal regulations or procedures	This is stipulated in life insurance policies. Examples: (Pacific Insurance) Seguros del Pacífico and Nicaraguan Insurance Institute (Instituto Nicaragüense de Seguros (INISER))
<b>Other Installations and Public Services</b>		
Denial or restrictions on access to public facilities (such as funeral services, transportation or sports facilities) due to HIV/AIDS status	Occurs in practice	Cases of transportation denied for PLWH. Daily Red Cross records

Source: Xochiquetzal Foundation

**ANNEX 4. SUMMARY TABLE OF SUCCESSFUL EXPERIENCES IN NICARAGUA 2006**

<b>Institution</b>	<b>Project</b>	<b>Initiated</b>	<b>Direction</b>	<b>Population Benefited</b>	<b>Zone</b>
Ministry of the Government	Global Fund Project – Nicaragua: Commitment and action against TB, Malaria and HIV/AIDS	2004	Prevention, promotion and treatment	Employees related to the Ministry of the Government as well as Prison inmates.	Urban and rural
Xochiquetzal Foundation*	Integrated attention program for PLWHA from the Xochiquetzal Foundation,	1992	Prevention, promotion and treatment, Integrated care (medical, psychological, legal).	General population, as well as PLWH.	Urban and rural

\**Contact.* The foundation's primary contact is Hazel Fonseca ([fxdir@enitel.net.ni](mailto:fxdir@enitel.net.ni)). Xochiquetzal's telephone number is 249-0585. The support line for PLWH is [fxlínea@enitel.net.ni](mailto:fxlínea@enitel.net.ni)



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